

A LEAP OF FAITH?

ENABLING HOSPICE STAFF TO MEET THE SPIRITUAL NEEDS OF PATIENTS

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Abstract: This article is based on research undertaken for the degree of Doctor of Ministry. Its focus is the investigation of two phenomena raised by members of hospice staff as impediments to the delivery of spiritual care. These are the problems of discerning the spiritual aspect of interventions with patients, and the apprehension staff feel in being faced with the prospect of meeting those needs for which they consider themselves unprepared. These two phenomena were tested by sharing with staff, six pastoral conversations and recording the degree to which they were able to pick up the spiritual content of the conversation. The research discovered that staff, although highly motivated, do not always have the confidence or the knowledge to address the spiritual needs of patients at an appropriate level of sophistication.

Key words: spiritual care; staff; hospice; training; Setting the Scene

I'd like to invite you to follow the journey of a patient called Gordon as he arrives at the Highland Hospice in Inverness for the first time:

Gordon arrives at the main entrance at 11 am as arranged, having travelled from home with his wife, Marjory, and son, Kenneth. At the door to greet them is Jean, one of the staff nurses.

"Good morning, Mr. MacTavish, I'm Jean, one of the nurses here and I'll be here to help you get sorted out." Gordon extends his hand and says,

"Good morning. Please call me Gordon." He then introduces Marjory and Kenneth.

"It's lovely to meet you both," says Jean, "now come with me and I'll show you your room." She leads them from reception through to the in-patient unit a short distance away. She explains the various features on the way, helping to put them at their ease.

"Now," says Jean, "this is the ward area. There are four single rooms in this part, and over here is the nursing office and outside is where the ward clerk sits. These are volunteers who keep things running smoothly and keep us nurses in order!"

Jean takes the three of them down to one of two three-bedded areas, showing them the conservatory and all its facilities as they pass.

"Now, Gordon, this is your bed, there's a chair here, and your locker is just beside you. There's another

gentleman called John in the room with you, but he's having a bath at the moment so I'll introduce you later. Now what would be more comfortable for you, the chair or lying on the bed?"

Gordon replies, "Och, the chair's fine for the moment, thanks." Jean then asks if he would like anything for pain but Gordon declines.

"Are you needing a hand to sort things out?" she enquires of Marjory.

"Thank you Jean, but I think I've got everything sorted." she says. She asks about visiting and Jean tells her that people can visit anytime.

"Now, I'll leave you to get settled for a wee while then I'll be back with Zoë who's one of the doctors and we'll get all your details. If there's anything you need or want to ask, I'll not be far away."

Once Zoë has taken Gordon's medical history and examined him, she leaves and Jean checks details about next of kin, family doctor's name and other essential pieces of information.

Jean heads off to the nurse's office and prepares the Initial Assessment Form which covers items such as mobility, personal goals, sleeping among others. When she gets to the box labelled 'Spirituality', Jean pauses. "What am I going to put in there?" she murmurs.

I had noticed on many occasions when I looked at patient notes, that the section Jean was concerned about was rarely filled in. I wondered why this was the case and so over the course of a six week period I took note of how many Forms had any information written in them. I discovered that fewer than one in eight had anything at all and they were mostly to do with a person's church membership.

I decided to ask members of staff about possible reasons for this lack of information and the answers suggested two possible impediments:

1. Sometimes staff were unclear about what to describe, or not aware that there was anything to describe. This I have called the problem of discernment.
2. Sometimes staff had some degree of uneasiness about the subject, and about how to respond to it, which meant that it wasn't discussed with the patient. This I have called the problem of apprehension.

If, as that straw poll suggested, staff don't understand what spirituality is, or don't know how to deal with it when identified as such, then, the chaplain who is charged with the responsibility of providing spiritual care, has a problem to solve.

Naturally a patient's spiritual concerns may occur at any time, and since there are never enough hours in the week, whether the chaplain's appointment be full or part time, there may not be time to wait for the chaplain to appear. It follows therefore that the onus of meeting spiritual needs and concerns must often fall on other members of the multi-disciplinary team. However, my impression was that, based on the evidence of the Initial Assessment Form and my conversations with staff, health care professionals were not always responding to these opportunities as they might. The research set out to test my hunch about the problems of discernment and apprehension and to suggest ways forward.

The focus of a Doctor of Ministry thesis is entirely on the act of ministry itself and can best be described in this case as examining a slice of chaplaincy in action; or to put it another way, it is akin to a biopsy of ministry. The D. Min's calculated choreography between theory and practice was ideally suited to examining the question in hand.

Methodology

In order to test the assumption made about apprehension and discernment it was decided to examine the conclusions, comments or observations, which staff drew out of certain pastoral situations.

During the course of normal pastoral duties verbatim accounts of six encounters with people, which I believed would throw light on the theory, were produced with their permission. In each encounter the best interests of the patient was always in mind, as the conversations recorded in the project were part of my ongoing pastoral work. The patient's details were altered to protect their identity, and although it was obvious to staff who these people were, they were bound by the same duty of confidentiality as I was.

These six verbatim accounts were then shared with different members of staff in an open ended discussion about what they understood to be the spiritual content in each case. Having talked to staff, I then reflected on what I learned from their comments and brought it to bear on my hunch about the twin impediments of discernment and apprehension.

Theoretically, the part played by the researcher is that of a participant observer. This is consistent with the goal of qualitative research, which is to "observe the ordinary"(Stake 1995), while the observer takes an active part with those being studied.

The project was grounded in phenomenological method which allows an approach to the phenomena of experience, in as fresh a manner and as free from conceptual presuppositions as possible, in order to describe them as faithfully as possible (Speigleberg 1975). As this implies a concern with the meanings that human beings use to interpret their experiences it was ideal for the purposes of this research dealing as it does with some of the deepest of human experiences.

Each pair of conversations, first with the patient and then with the staff member, became a case study in which we listened to the participants telling their story. Stake impresses on us the importance of the story by saying that much of our gathering of data from other people will take the form of stories they tell and much of what we can convey to our readers will preserve that form.

The story is a fundamental human tool, and can be used to say something about ourselves and the world as we see it.

Defining Spirituality

Perhaps it's not surprising that staff have difficulty filling in the 'spirituality' box. After all, what does it mean? And how is it understood specifically in the context of palliative care?

To create a base line from which to examine what is meant by spirituality a literature survey was undertaken and at the same time hospice staff not involved in the main project were asked what they understood by spirituality.

Despite one set of definitions being the result of scholarly labours and the other set coming from non academics it was interesting to note that both could be split into the same three groups.

1. the definition of spirituality is concerned with the essence of a person
2. the relationships with others and/or an infinite being
3. the search for meaning and purpose in life.

Tony Walter (Walter 1997) argues that the 'search for meaning' model of spiritual care is the most prevalent in current health care practice. While many definitions of spirituality based on this model do not have theistic orientations (Collinton 1998, Burkhardt 1989), Brigid Clark (Clark 1991) reports that experience of working with people facing a terminal illness in the hospice setting suggests that the majority of patients define their spirituality as their relationship with God.

If this is indeed the case, then any definition of spirituality that does not include the transcendent element of humanity's relationship to God will be sadly lacking. This is quite apart from any personal desire of the present writer to locate the spiritual firmly within the provenance of God.

Walter makes an important observation about spiritual care carried out by chaplains using a 'search for meaning' model. He comments that, what moves their care beyond psychotherapy or attentive listening is the language of forgiveness,

love and hope - words not often found in therapy sessions or texts on psychological counselling.

The definitive definition of spirituality may never be written but I would argue that it would have to include a sense of it being a lived experience, since to be spiritual is active, rather than passive. It encompasses an individual's relationship to God, or other idea of a higher power. It will also refer to the 'search for meaning' which is perhaps most pertinent to palliative care since it is at the point of facing the prospect of one's own mortality that questions of meaning and purpose take on heightened significance.

For the purposes of this project, spirituality was defined as *that part of a person's lived experience which seeks a relationship with God or other ultimate authority, and which endeavours to relate who they are to whose they are.*

Discussion

When I first noticed that the box labelled 'spirituality' on the Initial Assessment Form was more often than not left blank, I had no idea where this observation would lead me. My initial enquiries with members of staff about why this might be the case yielded two possible answers, which I labelled the problems discernment and apprehension. The research was concerned with finding evidence of those two problems in the conversations and reflections which were recorded.

What evidence was there of the problem of discernment?

Did members of staff find it difficult to discern spiritual needs and concerns?

There is probably less of a problem here than I imagined there might be. For example, a student nurse who responded to one man who sought forgiveness and absolution for past misdeeds is a good example of staff being able to discern spiritual needs. The nurse stayed with this individual out of a deep concern for him. She knew that there was a need and did what she could with the resources at her disposal. What prevented her interaction from bearing more fruit was a lack of knowledge about *how* to probe behind what was presented to her.

Another nurse, who was trying to make sense of a patient's feelings of estrangement as death approached, came to realise that she had recently made a crucial spiritual intervention almost without realising it. A third member of staff, on the other hand, thought she had uncovered a spiritual need (which was not in actual fact being presented) because she was unaware of the context in which certain comments were made by a lady whose faith was all important to her.

There is evidence then, that discernment of spiritual needs is an issue. This is caused by a number of things, such as, in the cases above, the inexperience of the student nurse who had not yet honed her skills. The lack of insight which the nurse dealing with estrangement at first displayed, or simple misunderstanding, as in the third case where a lack of knowledge led to reading a situation the wrong way.

What evidence was there of the problem of apprehension?

Judging by some of the comments made by members of staff in our conversations, apprehension can be a very real problem.

One member of staff interviewed mentioned the feeling that she, along with others, 'held back' in some situations for fear of 'saying something wrong'. She admitted to feeling out of her depth at times. More positively we can say that this person relates very well to those she cares for at a physical or emotional level, but does not find it easy to go beyond that into the spiritual. Another member of staff also admitted to difficulties when confronted with a situation in which a patient talks of spiritual pain. It was described as 'heavy', and dealing with it involved 'too much responsibility'. Knowing what to say to people presents a problem for more than one of the professionals I spoke to.

One nurse admitted to having concerns about the religious aspect displayed by a devout Christian lady. Another was uncomfortable with the thought of having to deal with issues of forgiveness and absolution raised in the case of a man seeking to tie up some loose ends in his life. Apprehension is undoubtedly caused by events, requests, or patterns of behaviour which we do not understand.

We should also note the difficulties a doctor experienced by identifying with a woman her own age,

which created tensions and a raising of the level of apprehension she felt in dealing with the woman's questions.

Conclusions

There is enough evidence here to support my original hunch, at least in part. In certain situations, staff can find themselves unaware of the extent of the issue before them. They may discern a need or concern but perhaps not the one that is at the root of the situation. They may also, under the same conditions, feel that they would rather not get too involved in the issue which has been identified. Calling in the chaplain is one answer to this problem, but it may not always be the best for the patient.

There are no hard and fast rules about when someone might encounter either of the problems mentioned above. An individual's beliefs, sensitivity, professional experience, life history, or even their mood on the day may make a difference as to how a situation is handled. The conversations I had with staff members describe people who are dedicated to caring for their patients and who truly have their best interests uppermost in their minds at all times.

As it is my responsibility as chaplain to 'enable' members of staff to respond to spiritual needs, I have looked for ways in which I can increase the sensitivity of staff to spiritual matters. They in turn should be more aware of spiritual needs when they arise and be more confident to tackle them at an appropriate level of sophistication.

The following are avenues for me to explore in the future:

There is a clear need for staff to understand what spirituality is about.

The definition which has underpinned this project will serve as a baseline against which to measure what may, or may not, be something spiritual. I am conscious that too tight a definition may be viewed as being restrictive, however I am also conscious that any exploration of ideas has to start somewhere.

To this end I have put in place a programme for all staff in which the spiritual needs and concerns of patients can be explored. *This will begin to tackle the problem of discernment.*

There are situations in which staff feel they do not have sufficient confidence to deal with the issues.

It is possible to learn from the experience of others, and see how they dealt with a given situation. Much of this can be gained while on the job, but there are times when reflection on one's practice is hugely beneficial. I believe this to be especially true in the whole area of spirituality.

To this end I intend to set up reflective workshops in spirituality at which health care professionals can discuss their experiences in a supportive atmosphere. *This will begin to tackle the problem of apprehension.*

Staff working in the Hospice should be encouraged to examine and develop their own spiritual life.

This is not only personally important but will have a marked effect on the level of spiritual care which they will be able to offer to patients. If staff have asked and answered for themselves at least some of the questions which they will be asked by patients, then this will go a long way to meeting their needs at the time that such help is required.

To this end I plan to develop workshops on spirituality at which staff will be able to address matters of faith and belief, both at a personal level, and within the context of caring for people who are dying. This will enable staff to be more spiritually aware and serve to tackle the problems of both discernment, and apprehension at a deeper level.

A personal reflection

And what have I, as chaplain, learned through this project? I have discovered anew the importance of what I do every day. It is an honour and a challenge to play a part in helping people live as fully as possible until they die.

I have also discovered anew the ministry of encouragement and enabling, particularly in the context of this project, with staff. I am also very conscious that in spite of all the debates on the nature of spirituality in health care, I am seen by many as God's representative in the Hospice. With that awesome responsibility comes the assurance of God's constant love and care, even to death.

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